U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 17 June 2004

In the Matter of:

TOMMY STACY, JR.,
Claimant

Case No.: 2003-BLA-5781

v.

D J & C COAL COMPANY, INC.,
Employer

and

OLD REPUBLIC INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Ron Carson
Vansant, Virginia
For the Claimant

Russell Presley, II, Esq.
Street Law Firm, LLP
Grundy, Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due

to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2003). In this case, the Claimant, Thomas Stacy, Jr., alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on November 4, 2003, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2003). At the hearing, Administrative Law Judge's Exhibit ("ALJX") 1, Director's Exhibits ("DX") 1-32, Claimant's Exhibits ("CX") 1-5 and Employer's Exhibits ("EX") 1-5 were admitted into evidence without objection. Transcript ("Tr.") at 7, 10, 12, 13. The record was completed at the hearing.

In reaching my decision, I have reviewed and considered the entire record.

PROCEDURAL HISTORY

The Claimant filed his initial claim on March 6, 1980. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on March 6, 1981, on the grounds that although the evidence showed that he had pneumoconiosis caused by coal mine employment, it did not show that the Claimant was totally disabled due to pneumoconiosis. The Claimant did not appeal that determination. DX 1.

The Claimant filed his current claim on March 4, 2002. DX 3. The Director issued a proposed Decision and Order denying benefits on January 22, 2003. DX 27. The Claimant appealed on January 24, 2003. DX 29. The claim was referred to the Office of Administrative Law Judges for hearing on April 10, 2003. DX 30, DX 32.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on March 4, 2002, inasmuch as it was filed more than a year after the prior denial. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2003), as amended at 68 Fed. Reg. 69935 (2003). Pursuant to 20 CFR § 725.309(d) (2003), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2003). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits.

Lisa Lee Mines v. Director, OWCP, 86 F.3d 1358 (4th Cir. 1996). As the Employer has conceded, Tr. at 5, and pulmonary function tests and arterial blood gas studies confirm, that the Claimant is now totally disabled by a pulmonary or respiratory impairment, the Claimant has proved the only element of entitlement previously decided against him. I have therefore considered all of the evidence in reaching my determination that he is not entitled to benefits.

ISSUES

The issues contested by the Employer, or by the Employer and the Director are:

1. Whether the claim was timely filed.

2. How long the Claimant worked as a miner.

3. Whether he has pneumoconiosis as defined by the Act and the regulations.

4. Whether his pneumoconiosis arose out of coal mine employment.

5. Whether his disability is due to pneumoconiosis.

6. Whether the named Employer is the Responsible Operator.

7. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2003).

DX 30; Tr. at 5-6, 27-28. Originally, the Director and the Employer also contested total disability, but the Employer conceded that issue at hearing Tr. at 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Mr. Stacy testified at the hearing. He was born in 1946 and was 57 at the time of the hearing. He has a seventh grade education. DX 1, DX 3, Tr. 14. His only dependent is his wife, Donnell, whom he married in 1965. DX 1, DX 3.

Mr. Stacy testified that he worked in the mines from January 1964 to the last part of 1979. He was never unemployed or off work for any extended time, other than an occasional hospitalization for a week or so for regulating his seizure medication. His last mine employment was for D J & C Coal Company from 1977 to 1979 as a mine operator. Tr. 15. His job required a lot of exertion, and was very dusty. Tr. 16-18. He stopped working because he hurt his back in a mining accident. Tr. 18. His last coal mine employment was in Virginia. DX 4, DX 7. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Mr. Stacy first noticed breathing problems before he quit the mine. He was treated for his breathing at first by Dr. Baxter in Grundy, Virginia, and later by Dr. J. G. Patel, whom he had been seeing for the past two or three years. Tr. 19-20. He has been using oxygen 24 hours a day for most of that time. He takes prednisone, Flovent, Atrovent and Albuterol. Tr. 20-21. He began smoking when he was young. He said he never told Dr. Patel he smoked 2 ½ packs a day for 35 years. He may have said that sometimes he went as high as 2 ½ packs, but not very often. When he worked in the mines, he did not smoke at all, but chewed tobacco. He quit smoking almost two years ago, in January 2002. Tr. 25-26. He denied that he was still smoking when he was examined by Dr. Fino in September 2002, or by Dr. Castle in May 2003. Tr. 27.

Mr. Stacy received workman's compensation benefits in a lump sum for his back injury. In 1982, he also filed for black lung benefits, and Social Security disability benefits based on depression, epilepsy and the back injury. Tr. 24. He did not know why his lawyer did not file a state rock dust claim as well. Tr. 25; *see* DX 8.

Timeliness

The purpose of the Regulation allowing the filing of subsequent claims is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). There is no statute of limitations or time limit for filing a subsequent claim. 20 CFR § 725.309 (2003); *Andryka v. Rochester Pittsburgh Coal Co*., 14 B.L.R. 1-34 (1990). While raising this issue to preserve it, Tr. 6, the Employer has offered no evidence or argument in support of this issue. I find that the claim is timely.

Length of Employment

The Social Security Administration records, DX 7, show coal mine employment which was not always full-time, but which spanned the years 1964 to 1979 as Mr. Stacy testified. Based upon the Social Security Administration records, which I find to be the most reliable evidence of record, and taking into account the Bureau of Labor Statistics Table of Average Daily Earnings, admitted as ALJX 1, I find that the Claimant had eleven years of coal mine employment.

Responsible Operator

The Claimant testified that he worked at D J & C Coal Company, Inc. from 1977 until 1979 as a mine operator. Tr. 15. This is verified by Social Security records. DX 7. There is no other coal mine employer for whom the Claimant worked for a period of at least one year after this employment; in fact, the Social Security records show no further employment of any kind after 1979. The evidence supports the conclusion that the Claimant was a miner last employed by D J & C Coal Company, a mine operator, which went bankrupt in 1979, but was insured by Old Republic Insurance Company during the relevant time period. DX 6, DX 13, DX 17. I find that D J & C Coal Company is the Responsible Operator in this case pursuant to 20 CFR §§ 725.491, 492 and 493 (2003).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2003). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of A and B-Readers issued by the National Institute of Occupational Safety and Health (NIOSH).[1] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A-reader; B= NIOSH certified B-reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
11/24/80	DX 1 Gale (B, BCR[2]) 2/1		

[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as A-readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as B-readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

[2] U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 21, 1999 (visited June 16, 2004), http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm; The American Board of Medical Specialties (visited June 16, 2004), http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
03/31/83	DX 1 Gale (B, BCR) 1/1		
01/10/01	CX 2 Miller (B, BCR) 2/3, A	EX 3 Wheeler (B, BCR)	
06/02/02			CX 5 D. R. Patel (A?[3]) COPD changes with scarring and chronic interstitial changes in the lungs. Compared with previous examination of 5/21/02, stable chest showing chronic changes
07/01/02	DX 9 Forehand (B) 1/2, 0	DX 21 Wiot (B, BCR)	DX 11 Barrett (B, BCR) Read for quality only, category 1
9/24/02	CX 1 Ahmed (B, BCR) 2/2, A	EX 3 Wheeler (B, BCR)	
10/17/02		DX 24 Fino (B) 0/0	
5/14/03		EX 1 Castle (B)	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV

[3] I cannot tell whether Dr. D. [for Dilip] R. Patel was still an A-reader in 2002. The comprehensive list on the OALJ website lists him as an A-reader from February 24, 1983 "to present." U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 21, 1999 (visited June 16, 2004) http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm. Dr. Dilip R. Patel does not appear on the current list of B-readers, which does not list A-readers as the comprehensive list did. CDC/NIOSH, NIOSH Certified B Readers List [Current readers] (visited June 16, 2004) http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.203(b)(2)(i) (2003).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 11/21/80 Berry	34 73”	3.36			39	No[4]	
DX 9 7/1/02 Forehand	56 72”[5]	1.37 1.59	3.14 4.05	44% 39%	30 35	Yes Yes	Obstructive ventilatory pattern.
DX 24 9/27/02 Fino	56 71.5”	1.45	3.40	43%		Yes	Combined obstructive and restrictive lung disease. Per Dr. Michos, DX 10, a valid study but suboptimal MVV performance.
EX 1 5/14/03 Castle	56 73”	1.23 1.53	2.55 3.06	48% 50%	33	Yes Yes	Valid study. Moderate obstruction with significant improvement after bronchodilators.
CX 3 8/11/03 Vansant Resp. Care	57 73”	1.05	2.78	38%		Yes	Very severe obstruction.

[4] Because the initial claim was filed before March 31, 1980, the regulations at 20 CFR Part 727 applied, rather than those at 20 CFR Part 718.

[5] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner, I have taken the average height (72.5”) in determining whether the studies qualify to show disability under the regulations. All of the tests except the one from 1980 are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	11/21/80	Berry	37.4	90.3	No[6]	
DX 9	7/1/02	Forehand	36 36	57 42	Yes Yes	Hypoxemia at rest and with exercise.
DX 24 CX 4	09/27/02	Fino	34.5	53.7	Yes	Moderately severe hypoxemia.
EX 1	5/14/03	Castle	35.7	50.9	Yes	Hypoxemia on room air.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2003). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2003). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2003). The record contains the following medical opinions relating to this case.

In connection with his first claim, Mr. Stacy was examined by Dr. Bradley D. Berry on behalf of the Department of Labor on November 21, 1980. DX 1. Dr. Berry took histories and

[6] Because the initial claim was filed before March 31, 1980, the regulations at 20 CFR Part 727 applied, rather than the regulations at 20 CFR Part 718.

conducted a physical examination, pulmonary function test and blood gas history. He recorded a smoking history of two packs per day for 16 years ending in 1978. Dr. Berry diagnosed COPD with moderate [sic], bronchitis, asthma, and epilepsy. He marked "yes" in response to a request for his opinion whether the diagnosed condition related to dust exposure, based on 15 years in coal mines. A chest x-ray taken a few days later, apparently in connection with the Department of Labor examination, was interpreted by Dr. Richard Gale as positive for pneumoconiosis, category 2/1. Dr. Gale said the x-ray revealed moderate interstitial fibrosis in the lung fields with some stippling in small nodule formation; the major fibrosis appeared to be irregular in character.

The Claimant was admitted to Buchanan General Hospital from June 3 to June 10, 2002. Dr. J. G. Patel was his treating physician. Dr. Patel is board-certified in internal medicine and pulmonary disease. He noted that the Claimant was seen in the emergency room because of increasing shortness of breath, cough and intermittent wheezing. According to the admitting record, Mr. Stacy was known to have a history of COPD with recurrent bronchitis, chronic changes in the right lower lung field with small density (scarring), seizure disorder, diverticulosis coli and previous history of colitis. He had a history of smoking two and a half packs of cigarettes per day for thirty-five years, and was currently smoking up to one pack per day, as well as chewing tobacco. Dr. Patel noted that a bronchoscopy was performed on March 21, 2002, to look for any malignancy or tuberculosis. A review of previous x-rays revealed persistent densities in the right lower lung field suggestive of scarring. A chest x-ray revealed chronic changes and scarring and no pneumonic process was noted. During his hospital stay, with treatment with antibiotics, bronchodilator medications and IV steroids, he improved sufficiently for release. Dr. Patel recorded discharge diagnoses which included (1) chronic obstructive pulmonary disease with acute exacerbation with bronchospasm; (2) eosinophilia; (3) chronic allergic rhinitis; (4) seizure disorder; (5) history of colitis; (6) chronic right lower lobe density; (7) diverticulosis coli; and (8) arthritis from history. CX 5.

Dr. J. Randolph Forehand examined the Claimant on behalf of the Department of Labor on July 1, 2002. DX 9. Dr. Forehand is board-certified in pediatrics and in allergy and immunology, as well as being a B-reader. A cigarette smoking history from 1972 to 2002 at the rate of one-half to one pack per day was recorded, the Claimant having quit smoking for a five year period during this time. Based upon his examination, which included the taking of histories and a chest x-ray, pulmonary function studies and blood gas testing, Dr. Forehand diagnosed coal worker's pneumoconiosis and emphysema. In his opinion the etiology of the cardiopulmonary diagnosis was coal dust exposure and cigarette smoking. He found a significant respiratory impairment to be present, rendering the Claimant totally and permanently disabled. When asked to explain the contribution of the diagnosed conditions to that disability, Dr. Forehand opined as follows:

> [C]oal worker's pneumoconiosis and emphysema combine to impair lung function. Appearance of chest x-ray and results of objective medical testing illustrative of the combined effects of both diagnoses. Cigarette smoking of greater importance, causing 60-70% of respiratory impairment.

Dr. Gregory Fino examined the Claimant on behalf of the Employer on September 27, 2002. DX 24. Dr. Fino is board-certified in internal medicine and pulmonary disease, as well as being a B-reader. Dr. Fino recorded a smoking history of one and a half packs of cigarettes per day for thirty-nine years, from 1963 until January of 2002. He also recorded a work history of 17 years in the mines. He took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. On physical examination, there were bilateral rales in the lungs. Dr. Fino read the x-ray as showing no pneumoconiosis; moderately severe pulmonary fibrosis in the two middle and lower lung zones was inconsistent with coal worker's pneumoconiosis. The pulmonary function test showed obstructive and restrictive lung disease and the arterial blood gas study revealed moderately severe hypoxemia. Carboxyhemoglobin level was normal. Dr. Fino also had the opportunity to review the Department of Labor examinations from 1980 and 2002, and reports of chest x-rays from 1980 and 1983. Based upon his examination and review of medical evidence, Dr. Fino concluded that the Claimant suffered from severe chronic obstructive pulmonary disease and severe pulmonary fibrosis. He found the chest x-ray to be very abnormal in this case, showing hyperinflation of the lungs and a diffuse increase in the interstitial markings in the middle and lower lung zones. This was consistent with diffuse interstitial pulmonary fibrosis, however, he reiterated that this type of abnormality was inconsistent with a coal mine dust-related pulmonary condition, which causes rounded opacities and first involves the upper right lung, then the left upper zone, then the two middle zones, and finally the two lower zones. The presence of only irregular opacities that spared the upper zones was inconsistent with a coal dust-related condition. Dr. Fino found a disabling respiratory impairment which was not disabling at the time that the Claimant retired from his coal mine employment. Dr. Fino opined that the abnormalities he saw were most consistent with a smoking-related pulmonary condition accounting for the chronic obstructive lung disease. He explained that the reversibility that was present and the significant worsening since 1980, over a period of time when the Claimant no longer worked in the mines, but continued to smoke, was consistent with a smoking-related disease. Dr. Fino continued as follows:

> However, there is an additional problem present which includes diffuse interstitial pulmonary fibrosis in the middle and lower lung zones. This diffuse interstitial pulmonary fibrosis is not related to coal mine dust inhalation. There is really no good evidence in the medical literature that diffuse interstitial pulmonary fibrosis may occur in coal worker's pneumoconiosis unless there is, in addition to diffuse interstitial pulmonary fibrosis, simple coal worker's pneumoconiosis present. Even in those cases, it has not been definitively shown that diffuse interstitial pulmonary fibrosis is related to coal mine dust inhalation.

Dr. Fino opined that the diffuse interstitial pulmonary fibrosis present in this case was idiopathic. While he found the Claimant to be totally and permanently disabled, he found this disability to be due to a combination of smoking and diffuse interstitial pulmonary fibrosis. Dr. Fino found that legal or simple coal worker's pneumoconiosis was not present and that it played no role in this disability.

Dr. James R. Castle examined the Claimant on May 14, 2003. EX 1. Dr. Castle is board-certified in internal medicine and pulmonary disease, and a B-reader. EX 2. He took

occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. He recorded a cigarette smoking history of a pack of cigarette daily, at times up to two packs per day. Dr. Castle estimated a 38 pack-year smoking history. The Claimant started at the age of seventeen years and quit smoking about a year and a half before the examination. Chest exam revealed increased AP diameter, and Mr. Stacy used accessory muscles for breathing when moving about the room. Breath sounds were decreased bilaterally, with a prolonged expiratory phase and scattered expiratory rhonchi, but no rales, crackles or crepitations. Dr. Castle found no pneumoconiosis on the chest x-ray. There was evidence of bullous emphysema, interstitial fibrosis in both mid and lower lung zones, and a pleural based scar on the right lateral chest wall. The pulmonary function test showed moderate airway obstruction with a significant change after bronchodilators, with gas trapping and moderately severe diffusion abnormality. The arterial blood gas study was abnormal at rest, so no exercise study was performed. Carboxyhemoglobin was significantly elevated. Dr. Castle concluded that the Claimant had no evidence of coal worker's pneumoconiosis by physical examination, radiographic examination and physiologic testing. He did find radiographic changes consistent with idiopathic interstitial pulmonary fibrosis; tobacco smoke induced pulmonary emphysema; elevated carboxyhemoglobin level; bronchial asthma; moderate airway obstruction with significant reversibility, gas trapping and reduction in diffusing capacity secondary to the emphysema and asthma; history of seizure disorder; and chronic hypoxemia requiring oxygen therapy.

Dr. Castle also had the opportunity to review medical records, including chest x-ray interpretations, pulmonary function studies, arterial blood gases and examinations from 2002 (not including the hospitalization record), as well as medical evidence submitted in connection with the 1980 black lung claim. He said that the exposure to dust from working 10.9 years in the mines was a relatively limited exposure history, but a susceptible individual could have developed coal workers' pneumoconiosis. He stated that the Claimant's elevated carboxyhemoglobin level was consistent with someone smoking about one pack of cigarettes daily. Based upon his examination and his review of the evidence, Dr. Castle opined that the Claimant did not suffer from coal worker's pneumoconiosis. He said that moderate airway obstruction with a significant degree of reversibility associated with gas trapping and a reduction in diffusing capacity were findings consistent with tobacco smoke induced pulmonary emphysema with an asthmatic component. He went on to state, "When coal workers' pneumoconiosis causes impairment it generally does so by causing a mixed, irreversible obstructive and restrictive ventilatory impairment. It is also very unusual for the diffusing capacity to be reduced due to coal workers' pneumoconiosis." While he did find the Claimant to be totally and permanently disabled from continuing his coal mine employment, that disability was not related to coal worker's pneumoconiosis, but to tobacco smoke induced pulmonary emphysema, bronchial asthma and interstitial pulmonary fibrosis. Dr. Castle stated that these are all conditions of the general public at large and unrelated to coal mining employment.

Mr. Stacy was hospitalized from July 14 to July 18, 2003, due to pneumonia in his left lung. Once again, Dr. J. G. Patel was the treating physician. Mr. Stacy was discharged with diagnoses of (1) left lung pneumonia; (2) chronic obstructive pulmonary disease with acute exacerbation; (3) paralytic ileus secondary to left lung pneumonia; (4) hyponatremia secondary to paralytic ileus; (5) chronic allergies and recurrent rhinitis; (6) seizure disorder; (7)

diverticulosis coli; (8) hyperbilirubinemia; (9) history of colitis; and (10) left-sided pleurisy. Dr. Patel noted that a chest x-ray on admission revealed left lung pneumonia with chronic changes in the right lung field. CX 5.

In a deposition taken by the Employer on October 27, 2003, Dr. Castle testified regarding his examination of May 14, 2003, as well as his review of medical records. EX 5. The other parties were notified of the deposition, but did not attend. Dr. Castle defined clinical pneumoconiosis as

> an inhalational lung disease whereby the inhalation of coal mine dust results in the development of abnormal chest x-ray findings that are defined as small, round regular opacities in the ILO system. This condition may or may not be associated with any respiratory impairment, and when it is, it is generally a mixed irreversible obstructive and restrictive pulmonary impairment …

EX 5 at 8-9. He defined legal pneumoconiosis as "a statutory definition indicating that it is a chronic dust disease of the lungs or the sequelae thereof that has been caused by contribute to, or substantially aggravated by coal mine dust exposure." EX 5 at 9. In preparation for the deposition, Dr. Castle reviewed additional records including records from the hospitalizations in June 2002 and July 2003 described above. Dr. Castle reiterated the opinion he gave at the time of the examination. It continued to be his opinion that the Claimant suffered from a tobacco smoke induced pulmonary emphysema, bronchial asthma, and interstitial fibrosis. Coal mine dust inhalation played no role in these conditions. In addition, he stated while the Claimant related a thirty-eight pack year history of cigarette smoking, the other data he reviewed would indicate that the Claimant had at least or up to as much as a 70 pack-year smoking history. With regard to the Claimant's elevated carboxyhemoglobin, Dr. Castle found that it was a higher level than one would expect for someone subjected to secondhand smoke. Asked about his diagnosis of interstitial pulmonary fibrosis, Dr. Castle said it is a condition in which scar tissue develops in the lungs for reasons not fully understood, primarily in the middle and lower lung zones, but not typically the upper lung zones. On x-ray it is manifested by linear irregular opacities. Dr. Castle opined that the Claimant did not suffer from complicated pneumoconiosis, as his comparison of the x-rays taken January 10, 2001, September 24, 2002, and May 14, 2003, showed no large opacities, but rather, a pleural based scar, possibly from an inflammatory process. Dr. Castle stated that the physical findings, pulmonary function tests and blood gas studies were indicative of bronchial asthma and tobacco smoke-induced bullous emphysema. In his opinion, Mr. Stacy did not have either clinical or legal pneumoconiosis. He saw no evidence of complicated pneumoconiosis.

Total Disability

Total disability has been conceded by the Employer in this case, a conclusion which is supported by the newly submitted objective laboratory data, as well as the medical opinions of Drs. Forehand, Castle and Fino. The crucial issue, therefore, is whether the Claimant's total disability is due to pneumoconiosis.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2003). In this case, the Claimant's medical records indicate that he has been diagnosed with interstitial fibrosis, chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only lung disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2003) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no biopsy or autopsy evidence. The presumptions set forth at Section 718.305 and 718.306 do not apply, because the Claimant filed

his claim after January 1, 1982, and he is still living. There is, however, evidence of complicated pneumoconiosis.

Pursuant to Section 718.304(a) the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under Section 718.304. Its existence may also be established under Section 718.304 (b) by biopsy or autopsy or under Section 718.304 (c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under Section 718.304 has been established. *Melnick v. Consolidated Coal Co*., 16 B.L.R. 1-31, 1-33 (1991) (en banc). The United States Court of Appeals for the Fourth Circuit has held that "…even where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) [biopsy or autopsy] or prong (C) [other means] then all the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray." *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F. 3d 250, 256 (4th Cir. 2000).

Drs. Miller and Ahmed found the x-rays they read to be positive for complicated pneumoconiosis. Both are dually qualified physicians, being B-readers and board-certified radiologists. Equally qualified physicians, Drs. Wiot and Wheeler found the x-rays they read to be negative for complicated pneumoconiosis. Additionally, Drs. Forehand, Fino and Castle, all of whom are B-readers, found the x-rays they read to be negative for complicated pneumoconiosis. Dr. Patel, who read the June 2, 2002, x-ray made no mention of large opacities. Based upon the preponderance of negative readings, I find that the existence of complicated pneumoconiosis has not been established by means of the x-ray evidence. There is no biopsy or autopsy evidence of record, nor is there any other evidence pursuant to this subsection, which establishes the existence of complicated pneumoconiosis. Moreover, in his deposition, Dr. Castle offered a detailed explanation of the reason for his opinion that the x-rays did not show complicated pneumoconiosis, a rationale which was not rebutted by any other doctor. Therefore, I find that the existence of complicated pneumoconiosis has not been established pursuant to Section 718.304.

I must also consider whether the chest x-rays and medical opinions establish the existence of simple pneumoconiosis. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137

F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the eight available x-rays in this case, two have been read only to be positive for pneumoconiosis, three have been read to be both positive and negative, one has not been read for pneumoconiosis and does not mention the disease, and two have been read only as negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2003); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. Woodward, 991 F.2d at 321; *see* Adkins, 958 F.2d at 52.

The two early x-rays from 1980 and 1983 have been read as positive by the same dually qualified reader, and must therefore be considered positive. As they precede the more recent x-rays by about 20 years, however, I give them little weight. I also note that Dr. Gale classified the 1983 x-ray as showing less profusion than the 1980 x-ray, belying the progressivity that would be expected with pneumoconiosis.

The January 10, 2001 x-ray was read as positive by one dually qualified physician and negative by one dually qualified physician. As the equally qualified BCR/B readers found pneumoconiosis to be both present and absent, I find that the readings of this x-ray are in equipoise as to the existence of pneumoconiosis.

The June 2, 2002 chest x-ray was read by Dr. Patel for purposes other than classifying pneumoconiosis, and mentions neither pneumoconiosis, nor any other cause of the COPD and chronic interstitial changes he observed. Whether an x-ray interpretation which is silent as to pneumoconiosis should be interpreted as negative for pneumoconiosis, is an issue of fact for the

ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co*., 6 B.L.R. 1-930 (1984). I find this x-ray to be neither positive nor negative.

The July 1, 2002 chest x-ray was read as positive by a B-reader and as negative by a dually qualified physician. Therefore, based upon the negative reading by the more highly qualified physician, I find this x-ray to be negative for pneumoconiosis.

The September 24, 2002 chest x-ray was read as positive by one dually qualified physician and negative by another dually qualified physician. I find the readings of this x-ray to be in equipoise as to the existence of pneumoconiosis.

The two most recent x-rays, taken on October 17, 2002, and May 14, 2003 were read as negative by B-readers. There were no positive readings of these x-rays. Both are negative.

As the readings of the six recent x-rays are in equipoise, neutral or negative, I find that the x-ray evidence is insufficient to establish the existence of pneumoconiosis under § 718.202(a)(1).

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the

nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2003). In this case, Mr. Stacy identified Dr. J. G. Patel as his current treating physician. However, the only records from Dr. Patel, from Mr. Stacy's hospitalizations, do not diagnose pneumoconiosis. While they do indicate a severe pulmonary condition, its etiology is not established to be coal mine dust inhalation.

Dr. Berry based his opinion that Mr. Stacy had pneumoconiosis on little evidence, made no mention of the role of smoking, and accepted a history of coal mine employment, and thus dust exposure, for longer than I have found. Because his opinion was not as well-reasoned or documented as any of the others, and because it was given over 20 years ago, his opinion is entitled to little weight. All of the other doctors who have given recent opinions in this case agree that Mr. Stacy now has disabling lung disease, but they do not agree on the cause. Dr. Forehand found the Claimant's lung condition to be due to coal worker's pneumoconiosis and emphysema, further finding that the Claimant's cigarette smoking history was of greater importance. Drs. Fino and Castle, however, find that the Claimant's pulmonary condition is due solely to factors other than coal mine dust inhalation. Dr. Forehand relies upon a smoking history which is considerably less than that relied upon by Drs. Fino and Castle; even so, he thought cigarette smoking to be of more importance than dust exposure. While there is a discrepancy in that history, I find that the Claimant smoked at least a pack of cigarettes per day, from when he was very young up to the present. While he claimed to have stopped smoking, the fact that his carboxyhemoglobin level was normal at the time of Dr. Fino's examination, but elevated at the time of Dr. Castle's examination, suggests that he may have quit for a while, but started again. Dr. Castle's finding of an elevated carboxyhemoglobin level renders the accuracy the Claimant's testimony regarding his smoking history questionable. Furthermore, the Claimant continued smoking for more than 20 years after he left the mines.

The Benefits Review Board has held that an Administrative Law Judge may properly discount a physician's opinion as to the causation of a miner's respiratory or pulmonary impairment when it is based on an inaccurate understanding of the miner's smoking history. See *Bobick v. Saginaw Mining Co.*, 13 B.L.R. 1-52 (1988); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1983). Given Dr. Forehand's erroneous smoking history, I find his report insufficient to establish the existence of pneumoconiosis. Moreover, he relied at least in part upon his own positive x-ray reading, while a more highly qualified physician found that x-ray to be negative. In sum, when weighing his medical opinion with the contrary medical opinions of record, and taking into account the fact that he is not a pulmonary specialist, while Drs. Fino and Castle are, I find the opinions of the latter two physicians worthy of greater weight.

Thus, after weighing all of the medical opinions of record, I accord greater probative weight to the opinions of Drs. Fino and Castle. Both possess excellent credentials in the field of pulmonary disease. Both had the opportunity to examine the Claimant as well as to review other medical evidence in the record. I also find their reasoning and explanation in support of their conclusions that coal dust did not cause either COPD or interstitial fibrosis more complete and thorough than that provided by Dr. Forehand, who concluded that the Claimant was disabled by

pneumoconiosis. Drs. Fino and Castle better explained how all of the evidence they developed and reviewed supported their conclusions. Their credible and well reasoned medical opinions are convincing for purposes of establishing that the Claimant is not suffering from coal worker's pneumoconiosis, and outweigh the contrary conclusion provided by Dr. Forehand. I conclude, therefore, that the weight of the medical opinions of record fails to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(4).

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2003); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990). As I have found that the evidence does not establish that Mr. Stacy has pneumoconiosis, he cannot establish that pneumoconiosis is a substantial contributor to his disability.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he has pneumoconiosis as defined in the Act and the regulations, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Thomas Stacy, Jr. on March 4, 2002, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2003), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at

P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.